

Academic/State/Federal Collaborations and the Improvement of Practices in Disaster Mental Health Services and Evaluation

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Abstract Academic, state, and federal agencies collaborated over the last 9 years to improve disaster mental health services and evaluation. This process, which included literature reviews, a number of expert panels, and case studies, is described. The products resulting from this process have included the development of a systematic cross-site evaluation of the federally funded crisis counseling program and field guides for interventions aimed at providing services to distressed individuals in the immediate aftermath of disasters and to individuals needing resilience skills training weeks or months after the event. Future improvement of disaster mental health services calls for continued research, evaluation, training, and intervention development.

Keywords Disaster mental health services

The challenges of bridging the gaps between research and practice are widely acknowledged in many fields of health and mental health care (Glasgow et al. 2003; Ringeisen et al. 2003). One result of existing disconnections between research and practice is that the standards of care in most

mental health treatment environments do not include the best validated, evidence-based interventions that are described in clinical practice guidelines. As with other areas of mental health, this remains true of services for those whose exposure to disasters has placed them at risk for development of a variety of mental health disorders, including posttraumatic stress disorder (PTSD), depression, and other problems. As a result, disaster mental health services have been challenged to provide care in a way that is consistent with current knowledge and conceptualizations of best practices.

Unfortunately, the state of the science in disaster mental health care means that those managing and delivering postdisaster mental health services have a relatively weak empirical literature on which to base design of services for survivors. Disaster crisis counseling services have been available in the United States for 34 years, but formal evaluation has played relatively little role in their evolution until recently, as detailed in the papers in this issue. Research on early interventions to prevent development of trauma-related problems in those exposed to other kinds of traumatic events represents another resource that can inform disaster-related services, one that has seen significant development in recent years (Litz and Maguen 2007). Up to the present time, given the limitations of the knowledge base, the challenge has been to develop practices based on a synthesis of three kinds of knowledge: consensus-based best practices guidance emerging from years of disaster-related mental health services delivery, information gleaned from methodologically-limited program evaluation efforts in disaster mental health, and research on traumatic stress and prevention of trauma-related problems. This paper details one effort towards bridging the gaps between science and practice in the field of disaster mental health.

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NCPTSD/CMHS History

For the last 9 years, the Center for Mental Health Services (CMHS), located within the Substance Abuse and Mental Health Services Administration (SAMHSA), has been collaborating with the Department of Veterans Affairs National Center for Posttraumatic Stress Disorder (NCPTSD), the National Child Traumatic Stress Network (NCTSN), and a select group of highly skilled private consultants to develop a state-of-the-art science-to-service effort. A key goal of this project has been to build a strong foundation for disaster technical assistance based upon the research literature as well as the accumulated experience and expertise of those delivering crisis counseling services. The aim has been to help promote high quality services and limit the proliferation of questionable practices with little or no evidence of effectiveness. The broad goal has been to translate current scientific and experiential knowledge into evidence-informed practices and public policies that will foster survivor and community resilience, and move toward more effective preventive and intervention services for disaster/terrorism survivors. In this paper, we outline the history of this effort, describe some of the key products, and speculate on aspects of future development of disaster mental health services.

Initial Project: Reviews, Panels, and Case Studies

When CMHS first approached NCPTSD in 1999, it was with a request to help inform improvements in the Crisis Counseling Assistance and Training Program (CCP), a program funded by the Federal Emergency Management Agency (FEMA) but administered by CMHS. The CCP was first authorized by the U.S. Congress under the Disaster Relief Act of 1974 (Public Law 93–288) and later modified by the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988 (Public Law 100–707). The goals of the CCP are to: (a) reach large numbers of people affected by disasters through face-to-face outreach to shelters, homes and other locations, (b) identify both tangible and emotional needs of survivors and make referrals to local disaster relief resources, as well as traditional behavioral health services, when necessary, (c) provide emotional support, education, basic crisis counseling, and connection to familial and community supports, and (d) leave behind a permanent legacy of improved coping skills, educational and resource materials, and enhanced community linkages. The CCP model is strengths-based, seeking to empower individuals and communities and to strengthen existing support systems. It seeks to be non-stigmatizing, proactive and flexible in delivery, and culturally competent. Assistance is focused upon providing disaster survivors with practical help in

coping with their current situation. To accomplish this goal, the CCP provides a range of services, including individual crisis counseling, group crisis counseling, public education, referral and resource linkage, and community support and networking.

The key questions CMHS put to NCPTSD in 1999 were, “Is our program supported by the latest disaster intervention research literature? And can we improve our training and services to be more in alignment with the empirical literature?” The first efforts to answer these questions were targeted at reviewing the extant disaster mental health intervention research literature, as well as attempting to systematically review current credible disaster mental health training programs. During the first 2 years of the interagency agreement, NCPTSD reviewed research on mental health crisis response protocols (Watson et al. 2003), disaster mental health training offered by various credible organizations (Young et al. 2006), and empirical research regarding the mental health consequences of disasters (Norris et al. 2002a, b). While each of these reviews provided insights for practice and policy, it quickly became apparent that the extant research was too limited to provide a solid evidence base for the design of postdisaster interventions. Thus the goals of the collaboration evolved to include additional approaches for capturing current standards and knowledge in the field. Initially, the most prominent among these approaches were consensus conferences and case studies of responses of mental health systems to disasters.

In 2000–2001, NCPTSD and SAMHSA collaborated with a number of Federal agencies, including the Department of Defense (Health Affairs, Uniformed Services University of Health Sciences, Walter Reed Army Institute of Research, consultants to the Surgeon General), the Department of Justice (Office of Victims of Crime), the National Institute of Mental Health (NIMH), and the American Red Cross, to co-sponsor a Consensus Workshop on *Mental Health and Mass Violence*. This conference, which coincidentally took place just a month after the September 11, 2001 terrorist attacks, brought together 70 national and international experts to develop a guidance document (National Institute of Mental Health 2002) that has had significant impact as various agencies have absorbed its recommendations. Subject matter experts answered critical questions about key components of intervention following mass violence, timing and execution of interventions, training and skills required to perform the interventions, and needs for research, evaluation, and ethical delivery of care. The key components of intervention were identified as: addressing basic needs (i.e., safety/security/survival, food and shelter), psychological first aid (basic support for the distressed), needs assessment (group, population, individual, recovery environment), outreach/

information dissemination, providing technical assistance, consultation and training, fostering resilience and recovery, triage (assessment and referral), and treatment. The group cautioned that early interventions in the form of single one-on-one recitals of events and emotions evoked by a traumatic event (stress debriefing) do not consistently reduce risks of later adjustment difficulties. And it stated that the field has an ethical duty to conduct research to move the field forward in delivering effective interventions. Much of the work of the consensus conference was subsequently published in a volume edited by Ritchie et al. (2006).

Other efforts to gather together experts followed. These efforts more fully explored the knowledge base and formulated consensus recommendations for specific disaster mental health-related challenges. For example, to address delivery of services under conditions of ongoing threat, a 2-day panel of international experts from the United States as well as countries that have experienced ongoing traumatic violence (i.e., Ireland, Israel, Palestine, among others) gathered to review the research literature, share treatment models that address the psychological issues associated with ongoing trauma exposure, and develop best practice guidelines for a coordinated mental health response to ongoing threats. A seminal article followed from this effort, identifying five principles of intervention in mass violence situations which provide a blueprint for disaster intervention organized around the principles of safety, calming, connectedness, self-efficacy, and hope (Hobfoll et al. 2007). In the same year, researchers and practitioners representing ethnic minority and other diverse communities were convened to participate in a 2-day meeting on cultural adaptation of evidence-based disaster mental health interventions for special populations. The meeting focused on translation and adaptation of screening and assessment instruments and outreach and intervention models for ethnic minority and other special populations. Program guidance and a book focusing on ethnocultural aspects of disaster followed from this effort (Marsella et al. 2008).

Concurrent with advocating for greater use of expert consensus to create program guidance, NCPTSD proposed to CMHS that the collection of original data on program practices would be helpful. Most previous writings on efforts to respond to disasters had been first-person narratives, rather than systematic independent accounts. Thus we embarked upon a series of detailed case studies of responses to major events, including the 1995 bombing of the Murrah Federal Building in Oklahoma City (Norris et al. 2005) and the September 11th World Trade Center attacks (Norris et al. 2006). The qualitative approach, findings, and recommendations were highly accessible to program officials, allowing the case studies to set the stage for subsequent quantitative evaluation in an important way. In Oklahoma, for example, the lack of empirical evaluation

data after the bombing fueled local debates over the quality of the work that was done. It was clear that CMHS needed to move in a direction that promoted the inclusion of evaluation in program plans.

Subsequent Evaluation and Intervention Development

The results of the literature reviews, consensus conferences, and case studies made two needs in the field particularly apparent: The first was for systematic, ongoing program evaluation. Beginning with an initial retrospective evaluation of past programs, NCPTSD and CMHS staff worked together to develop evaluation methods and data collection tools for the future, culminating in plans for an ongoing, cross-site program evaluation effort that was inaugurated after Hurricane Katrina (see Norris and Bellamy 2009; Norris et al. 2009; Rosen et al. 2009). The second critical need was for better guidance and training materials for service providers. As the multiple sources of information converged, it became clear that there were specific gaps in training materials, particularly in regard to program implementation, delivery of disaster mental health services immediately postevent (prior to the establishment of a CCP), and more intensive services designed for those who require assistance over and above crisis counseling, but who do not qualify for or are not willing to be referred for mental health treatment. To help fill the identified gaps in training materials, NCPTSD collaborated with other experts to create a variety of training products, including a disaster mental health video series, a program implementation manual, and the intervention model that is now known as Cognitive Behavioral Therapy for Postdisaster Distress (Hamblen et al. 2009).

By far, the particular product that generated the most attention was the “psychological first aid” (PFA) manual (National Child Traumatic Stress Network and NCPTSD 2005; <http://www.ncptsd.va.gov/pfa/PFA.html>). A considerable amount of discussion at the consensus conferences had centered around the lack of efficacy of stress debriefing models in preventing PTSD, which was the primary method of early intervention despite a growing amount of criticism (Bisson et al. 2009; McNally et al. 2003; Watson et al. 2003). An alternative model for early intervention was seen as a critical need by participating experts, and PFA emerged from these discussions as the recommended approach. Survivors sometimes require assistance in the first hours and days following disaster exposure, and it is important that such assistance be delivered in a way that is survivor-centered and effective but modest in its goals. In 2005, NCPTSD collaborated with NCTSN to design a detailed field operations guide that operationalized the components of PFA. Intended for use by disaster mental health responders and others who may be called upon to

provide immediate support for trauma survivors, PFA is comprised of eight core helping actions: contact and engagement, safety and comfort, stabilization, information gathering, practical assistance, connection with social supports, information on coping support, and linkage with collaborative services. The PFA Field Operations Guide describes these actions in detail, along with adaptations necessary for their application with children and adolescent survivors, as well as older adults. At present, there is little empirical evidence that any immediate intervention offered within hours of trauma can prevent development of mental health problems. However, PFA has been designed to be consistent with current traumatic stress research and theory, and it is hoped that systematization of current thinking about very early intervention within the PFA Field Operations Guide will stimulate research on the effectiveness of the approach. The creation of this document proved especially timely when, as Hurricane Katrina hit, there emerged a large demand for the PFA manual (Watson and Ruzek 2005).

From the outset, however, PFA was envisioned as only one aspect of a larger need for manualized guidance for service providers. Most extant crisis counseling approaches rely on interpersonal support, stress-related education, and normalization of acute stress responses. These are positive activities, but they may not be sufficient in addressing the needs of survivors exposed to disasters characterized by great intensity of individual exposure (Ruzek 2008; Wessely et al. 2009). To accelerate movement towards potentially more effective crisis counseling approaches, NCPTSD collaborated with NCTSN in 2006 to begin development of a manual adapting interventions that have been found effective in treating symptoms of PTSD, depression, and anxiety in non-disaster populations and settings or that address processes found to be important to postdisaster recovery. Dubbed “Skills for Psychological Recovery” or SPR, this evidence-informed intervention is intended to foster short- and long-term adaptive coping by offering simplified, brief application of interventions found effective in other service contexts: problem-solving training, positive activity scheduling, skills training in management of intrusive thoughts and emotional distress, cognitive reframing, and social support. SPR is intended to help survivors identify their most pressing current needs and concerns and teach and support them as they master skills to address those needs. While formal evaluation will be necessary to establish the effectiveness of SPR (and the manual is designed to facilitate evaluation efforts), training in SPR has been extremely well-received by counselors working in the Louisiana Spirit (Katrina) Specialized Crisis Counseling Services; they reported that the skills were highly practical and improved their ability to serve their clients.

Future of Disaster Mental Health Services

As evidenced by the efforts described above, as well as the findings in a number of the papers in this issue, NCPTSD’s multi-year collaboration with the CMHS has helped push the field in some important directions, grounding disaster mental health in the research literature, developing expert consensus guidance in areas where the research is limited, using systematic information gathering from field agencies to distill lessons learned from recent major disasters, developing training materials, establishing the first large-scale, multi-site, systematic crisis counseling program evaluation effort, and creating manualized interventions for multiple phases of mental health disaster response. Improvement of the field will now depend on its continued movement toward several key objectives. First, it must move towards more careful evaluation of services. The papers assembled in the present issue effectively demonstrate the potential of using standardized data across sites and events. Now it will be necessary to continue an evolution toward Norris and Rosen’s (2009) “evaluation culture” by creating a stable evaluation infrastructure and institutionalizing program evaluation. If the disaster crisis counseling and response community is to learn, cumulatively, from future experiences, it is vital that systematic information be gathered to facilitate assessment of effectiveness of individual response efforts, comparison of programs, and evaluation of program modifications.

Second, disaster mental health professionals must devote increased attention to delivery of evidence-based and evidence-informed interventions with survivors. Illustrated by the Baton Rouge Program, InCourage (Hamblen et al. 2009) following Katrina, cognitive-behavioral interventions that have been tested in other service contexts are increasingly being adapted and offered following disasters (cf., Ruzek 2006; Ruzek et al. 2008). Our work with SPR represents a continuation of this trend, but there remains a vital need for intervention development and evaluation. Because postdisaster care will often be sought in medical settings (Wang et al. 2008), efforts to integrate postdisaster mental health services into primary care medical settings are much needed. In addition, more development of family and dyadic early interventions is necessary (Cordova et al. 2003). The high demand for services in many disasters coupled with limited availability of trained mental health counselors means that group-based and classroom interventions must be actively developed and that innovative delivery systems will need to be explored. Chief among these will be Internet-based self-management, counselor-facilitated, and survivor mutual aid services; work is ongoing to develop and test such interventions (Benight et al. 2008).

Importantly, efficacious interventions will not be helpful if they are not used by those for whom they have

been designed. Despite high estimates of need for mental health services following Katrina (Norris and Rosen 2009), and a large body of research indicating significant and enduring effects on the mental health of survivors, Rosen et al. (2009) found a pattern of apparent under-referral for mental health services for Katrina survivors. The low rates of referral and actual use of formal mental health services demands research, service design, and policy attention. Up until recently, many disaster mental health services did not take steps to ensure that referrals were made in ways that were likely to succeed and it was not deemed important that efforts be made to encourage survivors to return for additional counseling sessions. In the PFA and SPR manuals, referral practices are explicitly addressed and a premium is placed on delivering multi-session services. This emphasis is borne out by the finding, reported in this issue, that participation in larger numbers of counseling encounters was associated with greater perceived benefits (Norris et al. 2009) and larger reductions in survivor distress (Jones et al. 2009). As noted by Hamblen and colleagues in this issue, improving motivation to stay in multi-session interventions can be challenging in postdisaster settings. Research should focus on ways of marketing services to survivors who need them and ways of delivering services that are more acceptable to survivors than traditional face-to-face counseling.

Finally, there is a profound need for the development and evaluation of training methods in the field of disaster mental health. This need is highlighted by impact of recent events like Hurricane Katrina. Any serious effort at dissemination of best practices in disaster mental health needs to start with recognition of the limitations of traditional training methods which form the basis of most current training in the disaster field. Research on best practices in behavioral health workforce education and training (e.g., Hoge et al. 2004) suggests that such training should be competency-based and that teaching methods themselves should be evidence-based. Training must be of sufficient intensity and interactivity (e.g., role-playing, discussion groups, experiential activities) to change provider behavior. It must incorporate the continued supervision, monitoring, and evaluation necessary to establish that providers have mastered their new skills and are continuing to do things differently following training. There is a need for increased accountability in disaster mental health services, and evolving training programs should move toward demonstration that training results in increased ability to perform a defined set of competencies that reflect the best available interventions for those who have had the misfortune to experience disaster.

All the efforts detailed in this special issue's articles make an effort to understand the varied needs of disaster

survivors, and to provide services that meet these needs, but more importantly, to evaluate the impact of services offered. None of this work is easily accomplished in an environment where chaos and overwhelming conditions rule. However, it is only by systematically attempting to introduce new interventions, while at the same time evaluating and improving services based on feedback gathered, that the field of disaster mental health can move forward. It is our hope that the valiant efforts detailed here will continue to yield more efficient and more effective interventions to offset the tremendous impact that disasters and mass violence can have on communities and individuals, and improve both natural resilience and recovery for those most affected.

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